

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

34583

FILED NOV 12 1948  
Registration District No. 1818

Primary Registration District No. 1003

Registrar's No.

9373

1. PLACE OF DEATH:

(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: The Peoples Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Infant Purnell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE

5. Color or race Negro

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased 10 (Month)

26 (Day)

48 (Year)

8. AGE:

Years

Months

Days

If less than one day

hr. 45 min.

9. Birthplace St. Louis, Missouri  
(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name A. C. Purnell

13. Birthplace Mississippi  
(City, town, or county)

(State or foreign country)

14. Maiden name Willie B. Kimbrough  
(City, town, or county)

(State or foreign country)

15. Birthplace Mississippi  
(City, town, or county)

(State or foreign country)

16. (a) Informant Hospital Record

(b) Address Anatomical Board

17. (a) Anatomical Board (Burial, cremation, or removal)

(b) Date thereof OCT 31 1948  
(Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board  
Rowland Mortuary Service

18. (a) Signature of funeral director 4104 Manchester Ave.

(b) Address OCT 31 1948  
(Date received local registrar)

(b) J. B. Lasater  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis, Missouri  
(c) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3832 Finney Ave.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 26  
year 48 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from OCT 26  
1948 to OCT 26, 1948  
that I last saw him alive on OCT 26, 1948  
and that death occurred on the date and hour stated above

Immediate cause of death

Cerebral Hemorrhage  
Due to Prolonged Labor

Due to

Cephalopelvic Disproportion  
Other conditions 16  
(Include pregnancy within 3 months of death)

Major findings:

Of operations Cesarean Section  
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place) (e) Means of injury  
23. Signature S. P. Barrett (M. D. or other)  
Address 2835a East Date signed 10-26-48

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**